



## Hyperthermic Cancer Treatment

<b>LOB(s):</b> <input checked="" type="checkbox"/> Commercial  <input checked="" type="checkbox"/> Medicare  <input checked="" type="checkbox"/> Medicaid	<b>State(s):</b> <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:  <input checked="" type="checkbox"/> Oregon
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### Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

### Background

Hyperthermic cancer treatment refers to the therapeutic use of controlled heat as an adjunct to standard oncologic treatments, including surgery, chemotherapy, and radiation therapy. These therapies are used to enhance the effectiveness of conventional cancer treatments and are delivered using different approaches based on location and treatment intent.

- A. Hyperthermic Intraperitoneal Chemotherapy (HIPEC) delivers heated chemotherapy directly into the peritoneal cavity following cytoreductive (debulking) surgery to treat residual microscopic tumors on peritoneal surfaces in selected intra-abdominal malignancies
- B. Local or regional hyperthermia targets tumors or defined anatomical regions and is used in adjunct within a multidisciplinary cancer treatment plan, most commonly in combination with radiation therapy .

### Criteria

#### Commercial

**Prior authorization is required.**

- A. PacificSource considers Hyperthermic Intraperitoneal Chemotherapy medically necessary when used at time of or after cytoreductive (debulking) surgery for **ANY** of the following conditions:

1. Malignant peritoneal mesothelioma with metastasis limited to the abdominal cavity
  2. Peritoneal carcinomatosis from gastric cancer (e.g., Appendix, Colon, Rectal, Pancreatic and Gastric Cancers) without extra-abdominal metastases
  3. Pseudomyxoma Peritonei
  4. Stage II or Stage III epithelial ovarian cancer
- B.** PacificSource considers Local or Regional Hyperthermia cancer treatment to be medically necessary when **ANY** of the below criteria is met:
1. Regional hyperthermic melphalan perfusion treatment in members with Stage II, III A, and Stage III in-transit extremity melanoma
  2. Other Local or Regional external hyperthermia treatment when **ALL** of the following is met:
    - a. In conjunction with radiation therapy as part of treatment plan
    - b. Diagnosis of primary or metastatic cutaneous or subcutaneous superficial malignancies (e.g., superficial recurrent melanoma, cervical lymph node metastases)

### Medicaid

PacificSource Community Solutions follows the hierarchical process detailed in the "Clinical Criteria Used in UM Decisions" policy when determining coverage for Hyperthermia for treatment of cancer. PCS evaluates services based on the relevant coverage guidelines, limitations, and restrictions specified in the OHP Prioritized List of Health Services and its guidelines, as well as any applicable Oregon Administrative Rules (OARs).

PacificSource follows the "Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)" criteria for members under 21 and Young Adults with Special Health Care Needs (YSHCN).

PCS follows the "Unlisted and Unspecified Procedure Codes" policy for requests for unlisted codes.

### Medicare

PacificSource Medicare follows National Coverage Determination (NCD) 110.1 Hyperthermia for treatment of cancer.

### Experimental/Investigational/Unproven

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PacificSource considers Hyperthermic Intraperitoneal Chemotherapy to be experimental, investigational, or unproven for any other indications.

PacificSource considers Whole Body Hyperthermia to be experimental, investigational, or unproven for any indication. (e.g., warm-water blankets, inductive coils (like those in electric blankets) or thermal chambers (similar to large incubators).\*

**Note:** \* indicates the item remains E/I/U but will not be reviewed annually by the NTOC Committee, unless requested.

**Note:** PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy,

“Clinical Criteria Used in UM Decisions” to review criteria hierarchy and “Medical Necessity Reviews” for determination of coverage and medical necessity guidelines.

## Coding Information

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The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

- 77600 Hyperthermia, Externally Generated; Superficial
- 77605 Hyperthermia, Externally Generated; Deep
- 77610 Hyperthermia Generated, Interstitial Probe(S); Up To 5 Interstitial Applicators
- 77615 Hyperthermia Generated, Interstitial Probe(S); > 5 Interstitial Applicators
- 77620 Hyperthermia Generated, Intracavitary Probe(S)
- 96446 Chemotherapy administration into the peritoneal cavity via indwelling port or catheter
- 96547 Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)
- 96548 Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)
- 96549 Unlisted chemotherapy procedure

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## Definitions

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**Appendiceal Cancer** - A rare malignancy arising from the appendix, including mucinous adenocarcinoma, colonic-type adenocarcinoma, signet-ring cell carcinoma, goblet cell carcinoma, and neuroendocrine tumors, which may disseminate within the peritoneal cavity.

**In-Transit Melanoma** - Metastatic melanoma presenting as cutaneous or subcutaneous tumor deposits located between the primary melanoma site and the regional lymph node basin.

**Malignant Peritoneal Mesothelioma** - A rare aggressive malignancy originating from the mesothelial lining of the peritoneum, often associated with asbestos exposure, and typically confined to the abdominal cavity at presentation.

**Pseudomyxoma Peritonei (PMP)** - A clinical condition characterized by intraperitoneal dissemination of mucin-producing tumor cells, most commonly arising from appendiceal or ovarian neoplasms, resulting in progressive accumulation of mucinous ascites.

**Stage III Ovarian Cancer** - Epithelial ovarian cancer involving one or both ovaries with metastatic spread beyond the pelvis to the peritoneum and/or retroperitoneal lymph nodes.

## References

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## Related Policies

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Clinical Criteria Used in UM Decisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Unlisted and Unspecified Procedure Codes

## Appendix

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**Policy Number:**

**Effective:** 7/1/2020

**Next review:** 7/1/2027

**Policy type:** Enterprise

**Author(s):**

**Depts:** Health Services

**Applicable regulation(s):** 42 CFR § 422.101(b-c) OARs 410-120-1200, 410-141-3820, 410-141-3825, 410-151-0000 through 0003;

**OPs Approval:** 5/2026